A. CLAIM FORM INSTRUCTION

General billing procedures and reimbursement policy are in the WMAP Part A Provider Handbook. Sample HealthCheck case management claims are in Appendix 4 of this handbook.

B. CLAIM SUBMISSION

In order to claim reimbursement for outreach, case management providers must have on file verification that the HealthCheck screening occurred. This verification may be received in written form or through a conversation with either the provider or the recipient.

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at::

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

HealthCheck services must be submitted using the National HCFA 1500 claim form. Sample claim forms can be found in Appendix 4 of this handbook. Claim form completion instructions can be found in Appendix 3 of the WMAP Part D, Division I HealthCheck Handbook. When billing with claim sort indicator "H," physician services must be submitted on a separate claim form from HealthCheck services using the appropriate claim sort indicator for each type of claim.

HealthCheck services submitted on any paper form other than the National HCFA 1500 claim form are denied.

The National HCFA 11500 claim form is not provided by the WMAP or the fiscal agent. It may be obtained from a number of sources, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

B. CLAIM SUBMISSION (continued

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784

Submission of Claims
All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy applies to all initial claim submission, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals can be found in Section IX of Part A of the WMAP Provider Handbook

C. PROCEDURE CODES

Outreach/case management providers may claim reimbursement when either targeted or non-targeted outreach has been provided that results in a comprehensive HealthCheck screening by either the same agency or an outside screener, such as a physician clinic. Case management for assisting the recipient in scheduling follow-up appointments to the screening is part of the total service.

Two outreach/case management billing codes are available:

W0712 Targeted outreach/case management
W7014 Non-targeted outreach/case management

D. MODIFIERS

When billing for outreach, one of the currently allowable modifiers is required if claim sort indicator "H" is used on the claim. Claim sort indicator "H" is allowable for claims received by the fiscal agent not later than 6/30/95.

If claim sort indicator "P" is used, no modifier is required. Claim sort indicator "P" is allowable for claims received by the fiscal agent beginning 2/15/95. Refer to Appendix 5 for a summary of the billing options available.

E. DATE OF SERVICE

Outreach case management is a service that spans over a time period. If possible, for billing purposes, use the screening date as the date of service recorded on the claim.

F. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to the fiscal agent. Processed claims will appear on the Remittance and Status Report either as paid, pending or denied. Providers should be advised that the fiscal agent will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for filing an adjustment request form to the fiscal agent. Section X of the WMAP Part A Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.